310 COVERED SERVICES

- **AUDIOLOGY**

Description. Audiology is an AHCCCS covered service, within certain limitations, to evaluate hearing loss and rehabilitate persons with hearing loss through other than medical/surgical means.

Amount, Duration and Scope. AHCCCS covers medically necessary audiology services to evaluate hearing loss for all members, on both an inpatient and outpatient basis. Hearing aids can be dispensed only by a dispensing audiologist or an individual with a valid hearing aid dispensing license. Hearing aids, provided as a part of audiology services, are covered only for members receiving EPSDT services and KidsCare members up to age 21.

Beginning June 28, 2004, audiology services must be provided by an audiologist who is licensed by the Arizona Department of Health Services (ADHS) and who meets the Federal requirements specified under Title 42 of the Code of Federal Regulations (42 CFR) 440.110. Out-of-state audiologists must meet the Federal requirements.

The Federal requirements mandate that the audiologist must have a Master's or Doctoral degree in audiology and meet one of the following conditions:

1. Have a certificate of clinical competence in audiology granted by the American Speech-Language-Hearing Association (ASHA), or

2. Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or be in the process of accumulating such supervised clinical experience under the supervision of a qualified Master's or Doctoral-level audiologist), performed not less than nine months of supervised full-time audiology services after obtaining a Master's or Doctoral degree in audiology or a related field, and successfully completed a national examination in audiology approved by the Secretary of the U.S. Department of Health and Human Services.

Refer to Chapter 1200 for additional information on services provided to ALTCS members.

BEHAVIORAL HEALTH SERVICES

Description. AHCCCS covers behavioral health services (mental health and/or substance abuse services) within certain limits for all members except those enrolled to receive family planning extension services only. The following outlines the service delivery system for behavioral health services.

Acute Care Program

1. Title XIX and Title XXI Members are eligible to receive medically necessary behavioral health services. Services are provided through the Arizona Department of Health Services and its contracts with Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs). Native American members may receive behavioral health services from an IHS/638 facility, a TRBHA, or be referred to a RBHA. Services are listed in the amount, duration and scope section of this policy and described with limitations in Appendix G, the Behavioral Health Services Guide. Managed care primary care providers, within the scope of their practice, who wish to provide psychotropic medications and medication adjustment and monitoring services may do so for members diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder, mild depressive and/or anxiety disorders.

   Contractors are responsible for providing inpatient emergency behavioral health services for up to 72 hours after admission to managed care members with psychiatric or substance abuse diagnoses who are enrolled with a Contractor and are not behavioral health recipients (not to exceed 12 days per contract year).

2. Family Planning Extension Program Members enrolled in the SOBRA Family Planning Extension Program are not eligible for behavioral health services.

Arizona Long Term Care System (ALTCS) Program

ALTCS members are eligible to receive medically necessary behavioral health services through ALTCS Contractors, Tribal Contractors, Department of Economic Security/Division of Developmental Disabilities, and AHCCCS registered fee-for-service (FFS) providers. Refer to Appendix G and Chapters 1200 and 1600 of this Manual for additional information regarding ALTCS behavioral health services.

Amount, Duration and Scope.

Covered behavioral health services for acute and ALTCS members include, but are not limited to:

1. Inpatient hospital services
2. Inpatient psychiatric facility services including subacute facilities and residential treatment centers for persons under age 21
3. Institution for mental disease with limitations (See Appendix G)
4. Behavioral health counseling and therapy, including electroconvulsive therapy
5. Psychotropic medication
6. Psychotropic medication adjustment and monitoring
7. Respite care
8. Partial care (supervised day program, therapeutic day program and medical day program)
9. Behavior management (behavioral health personal care, behavioral health home care training, behavioral health self-help/peer support)
10. Psychosocial rehabilitation (skills training and development, behavioral health promotion/education, psychoeducational services, ongoing support to maintain employment, and cognitive rehabilitation)
11. Screening, evaluation and assessment
12. Case management services
13. Laboratory, radiology, and medical imaging services for diagnosis and psychotropic medication regulation

14. Emergency and non-emergency medically necessary transportation

15. Behavioral health therapeutic home care services, and/or

16. Emergency behavioral health services for managed care and FFS members who are not in the FESP (refer to Chapter 1100 for all requirements regarding FESP).

    a. Emergency behavioral health services are described under A.A.C. R9-22-210.01. An emergency behavioral health condition is a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

        1) Placing the health, including mental health, of the member in serious jeopardy (this includes serious harm to self)

        2) Serious impairment to bodily functions

        3) Serious dysfunction of any bodily organ or part, or

        4) Serious physical harm to another person.

    Acute symptoms include severe psychiatric symptoms.

    b. An emergency behavioral health evaluation is covered as an emergency behavioral health service if:

        1) Required to evaluate or stabilize an acute episode of mental disorder or substance abuse, and

        2) Provided by a qualified provider who is:

            a) A behavioral health medical practitioner as defined in 9 A.A.C. 22, Article 1, including a licensed psychologist, a licensed clinical social worker, a licensed professional counselor, a licensed marriage and family therapist, or

            b) An ADHS/DBHS-contracted provider.

A provider is not required to obtain prior authorization for emergency services. Regarding emergency services, refer to Exhibit 310-1 for a reprint of A.A.C. R9-22-210.01 that describes general provisions for responsible entities, payment and denial of payment, notification requirements and post-stabilization requirements.

Refer to A.A.C. R9-22-217 and Chapter 1100 of this Manual for information regarding behavioral health services for members eligible for services through the Federal Emergency Services Program.

Refer to Chapter 1200 for more information regarding behavioral health services for members eligible for the ALTCS program.

Refer to Appendix G for further information on AHCCCS covered behavioral health services and settings.

- **BREAST RECONSTRUCTION AFTER MASTECTOMY**

Description. AHCCCS covers breast reconstruction surgery for eligible members following a medically necessary mastectomy regardless of AHCCCS eligibility at time of mastectomy.

Amount, Duration and Scope. Breast reconstruction surgery is a covered service if the individual is AHCCCS eligible, and as noted in this section. The member may elect to have breast reconstruction surgery immediately following the mastectomy or may choose to delay breast reconstruction, but the member must be AHCCCS eligible at the time of breast reconstruction surgery. The type of breast reconstruction performed is determined by the physician in consultation with the member.

Coverage policies for breast reconstructive surgery include:

1. Reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is considered an effective non-cosmetic procedure. Breast reconstruction surgery following removal of a breast for any medical reason is a covered service.

2. Medically necessary implant removal is a covered service. Replacement of implants is a covered service when the original implant was the result of a medically necessary mastectomy. Replacement of implants is not a covered service when the purpose of the original implant was cosmetic (e.g., augmentation).

3. External prostheses, including a surgical brassiere, will be covered for members who choose not to have breast reconstruction, or who choose to delay breast reconstruction until a later time. Refer to the durable medical equipment (DME) policy in this Chapter for information regarding covered DME services.

Limitations:

1. AHCCCS does not cover services provided solely for cosmetic purposes (R9-22-205). If a member has had an implant procedure for cosmetic purposes (e.g., augmentation) not related to a mastectomy, medically necessary removal is covered but replacement is not.

2. Reconstructive breast surgery of the unaffected contralateral breast following mastectomy will be considered medically necessary only if required to achieve relative symmetry with the reconstructed affected breast. Except in extraordinary circumstances, the medical necessity of reconstructive breast surgery must be determined by the surgeon, in consultation with the Contractor's Medical Director, at the time of reconstruction or during the immediate post-operative period.

Prior authorization (PA) from the AHCCCS Division of Fee for Service Management is required for breast reconstruction surgery provided to FFS members. Refer to Chapter 800 for further discussion of PA requirements for FFS providers.